healing hands
massage • spa • boutique • salon

Our services are done by licensed professionals. This time is for you. Please communicate any problems or discomforts during your session. ENJOY your treatment!

PERSONAL INFORMATION • • •

Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Phone #: Home (____) ____ - _____ Mobile (____) ____ - _____ Work (____) ____ - _____

Email (for appointment reminders + specials): _____

Occupation: _____ How did you hear about us? _____

Method of Payment (circle all that apply): GIFT CERTFICIATE INSURANCE CASH/CREDIT/CHECK

MEDICAL HISTORY • • •

1. Physician/Chiropractor: _____

2. Currently Under Doctor's Care? YES NO Conditions: _____

3. Recent/Past Injuries & Surgeries: _____

4. Medications: _____

5. Hobbies/Exercise: _____

6. Conditions - WE MUST KNOW FOR YOUR SAFETY! (circle all that apply):

Allergies (accutane or shellfish) List: _____

Asthma
Back/Shoulder Conditions
Broken Bones
Cancer (current or remission)
Cardiac Problems
Diabetes
Eczema
Epilepsy
Fever Blisters
Headaches/Chronic
Head or Neck Injuries
Hepatitis
Herpes
High Blood Pressure
Hypertension
Hysterectomy
Immune Disorders
Lupus
Metal bone pins or plates
Pacemaker
Psychological
Sinus Problems
Skin Diseases
Surgeries
Urinary or Kidney Problems
Varicose Veins

MASSAGE • • •

1. Have you received a professional massage before? YES NO
2. Are you pregnant or planning? YES NO
3. Are you wearing contacts? YES NO
4. What do you need out of your massage? _____
5. Questions/Concerns? _____

PEDICURE, MANICURE, GEL POLISH • • •

1. With respect to your feet or hands, which of these conditions do you experience? (circle all that apply)

Cold Feet	*Peeling Skin*	*Skin Fungus*	*Tired Sensation*	*Corns*
Dry Skin	*Sweating*	*Nail Fungus*	*Heavy Sensation*	*Plantar Warts*
Cracked Skin	*Hot Feet*	*Discolored Nails*	*Foot Odor*	
Itchiness	*Blisters*	*Thick Nails*	*Callus Build-up*	

2. What improvements would you like to see? _____
3. Are you being treated for diabetes? YES NO
4. Allergies List _____
5. Current medications _____
6. Do you have sensitivty to UV light? YES NO

SPA TREATMENT, FACIAL & WAXING • • •

1. Is this your first treatment?	*YES*	*NO*
2. Are you taking birth control?	*YES*	*NO*
3. Do you wear contact lenses?	*YES*	*NO*
4. Do you smoke?	*YES*	*NO*
5. Are you currently being treated with chemotherapy?	*YES*	*NO*
6. Have you used any Glycolic or Alpha Hydroxy Acid products in the last 48 hours?	*YES*	*NO*
7. Are you currently using Retain A products, Acutane or Renova?	*YES*	*NO*
8. Have you recently received a chemical peel?	*YES*	*NO*
9. Are you exposed to sun on a daily basis?	*YES*	*NO*
10. Do you regularly use a tanning bed?	*YES*	*NO*
11. Do you have any allergies to cosemetics, foods, seaweed, shellfish, or drugs?	*YES*	*NO*

If yes, please list _____

This is to acknowledge that I have been informed of all aspects of my waxing service and that I understand that I may experience possible redness and or skin irritation's. It is with this understanding that I agree to have these services and I accept all responsibility for such thereby releasing the Spa and the service provider from liability. I am over/under twenty one years of age.

*SIGNATURE:*_____*DATE:*_____